What the Health and Mental Health Care Systems Can Do To Make a Difference

- **Conduct public health campaigns.** Establish sexual assault, dating and domestic violence, and stalking as serious public health issues through national, state, and local campaigns by health and mental health departments, health and medical associations, and health care institutions.
- **Educate all health care providers about violence against women.** Fully integrate information on the prevention, detection, and appropriate treatment of sexual assault and domestic violence into curriculums at all health and mental health care professional schools and continuing education programs. Encourage every health plan and provider group to provide training on domestic violence screening, intervention, documentation, and referral.
- **Create protocol and documentation guidelines for health care facilities, and disseminate widely.** Encourage the use of standard chart prompts, documentation forms, and provider reference materials on sexual assault and dating and domestic violence.
- **Protect victim health records.** Enact statutes, policies, and procedures that prevent discrimination against victims, enhance victim safety and privacy, and allow victims to restrict access to their patient information.
- **Ensure that mandatory reporting requirements protect the safety and health status of adult victims.** Examine and amend state statutes regarding domestic violence mandatory reporting to require victim consent before reporting in cases involving adult victims unless the injury is gunshot-related or life threatening.
- **Create incentives for providers to respond to violence against women.** Create reimbursement codes and mechanisms, quality assurance procedures, and packaged service provision programs for domestic violence, and implement strategies specifically geared toward sexual assault as recommended by the national sexual assault task force.
- **Create oversight and accreditation requirements for sexual assault and domestic violence care.** Require that institutions identify, document, assess, and respond to sexual assault and domestic violence victims' needs as part of routine licensing and credentialing procedures.
- **Establish health care outcome measures.** Create measures for evaluating victim health and mental health status improvement as response to violence against women is enhanced.
- **Dedicate increased federal, state, and local funds to improving the health and mental health care systems' responses to violence against women.** Include exploring the creation of new funding streams and earmarking specific funding within state and local health department budgets.

Chapter 2

Improving the Health and Mental Health Care Systems' Responses to Violence Against Women

Millions of women are victims of sexual assault, dating or domestic violence, or stalking at some point in their lives, and the traumatic effects of this violence have a tremendous impact on survivors' physical and mental health. Too many victims never discuss incidents of violence with anyone or approach the health and mental health care, criminal justice, or other system for assistance. However, most women come to health care settings for regular exams, for treatment of specific problems both caused by and independent of the abuse, and for the care of their children and other family members. Health care providers may be the first and only professionals who see a battered woman or sexual assault victim. This makes the health and mental health care systems crucial points for early intervention and prevention for women who have survived or are experiencing violence.

The health effects of violence against women are extensive. In addition to possible acute injuries sustained during sexual assault or dating or domestic violence, physical, sexual, and psychological abuse are linked to numerous adverse chronic health conditions. These include arthritis, chronic neck or back pain, frequent migraines or other types of headaches, visual problems, sexually transmitted infections, chronic pelvic pain, increased gynecological symptoms, peptic ulcers, and functional or irritable bowel disease.[1]

Violence against women is also directly related to adverse mental health effects. Sexual assault trauma and domestic violence are often life-altering experiences resulting in numerous emotional and behavioral responses.

Sexual assault victims are more likely than other crime victims to attempt suicide.[2] More than one-third of sexual assault victims and battered women experience symptoms of depression.[3] Forty-six percent of domestic violence victims have symptoms of anxiety disorder.[4] Victims of both sexual assault and domestic violence experience symptoms consistent with posttraumatic stress disorder.[5] Persistent sexual victimization occurring early in childhood can lead to a range of disorders that can arise anytime after the traumatic event and last indefinitely until appropriate treatment is received. Resulting behaviors, such as drug abuse or prostitution, may be deemed criminal and may result in the person being punished. Numerous studies nationwide consistently show prevalence rates of sexual abuse histories at 22–54 percent among women receiving case management mental health services and 50–70 percent among women in inpatient psychiatric facilities.[6]

Unfortunately, many health and mental health care providers still do not view sexual assault, dating and domestic violence, and stalking as public health issues and lack the knowledge, skills, and incentives to intervene appropriately. For example, only 9–11 percent of the primary care physicians in California routinely screen patients for domestic violence during new patient visits, periodic check-ups, and prenatal care.[7] One study in which participants represented patients and physicians in both a private and a public hospital concluded that both patients and physicians favored the practice of doctors inquiring about physical and sexual abuse—yet 89 percent of the physicians never made such inquiries.[8]

Sexual Assault and Domestic Violence as Overlapping but Distinct Health Issues

For this discussion, it is important to understand the interconnections and distinctions between sexual assault and domestic violence and their implications for health and mental health care system intervention. Medical treatment differs dramatically for survivors of sexual assault and domestic violence. Although competent medical treatment is critical for both, it must occur immediately—from the moment a sexual assault survivor or domestic violence victim arrives at a health care facility. In cases of sexual violence, a victim may have contracted a sexually transmitted disease as a result of her assault, and pregnancy is often an overwhelming and genuine fear. Therefore, immediate and continued access to a full range of reproductive health care services is particularly important for sexual assault victims. Long term, the followup care for victims of sexual assault and dating and domestic violence may involve different types of treatment, referrals, and support. Factors such as duration of abuse, unreported history of earlier victimization, ongoing safety concerns, and cultural influences are just some of the needs to consider.

Primary and Secondary Prevention of Violence Against Women

Health problems of the magnitude described above require a broad public health approach with comprehensive prevention strategies and commitment to ongoing evaluation. When such strategies are effective, they can prevent health problems (primary prevention) or identify a problem in its earliest stages (secondary prevention). In this way, harm to individuals is reduced, and the long-term adverse impact on a patient's health (including mental health) is minimized. For example, early detection programs for breast, cervical, and prostate cancer can identify and treat these problems before the disease reaches advanced stages. When primary or secondary prevention strategies are not implemented or are ineffective, tertiary prevention—a strategy that limits the impact of an injury or disability once it has become serious—is needed.

Until recently, the health care system has addressed sexual assault and domestic violence predominantly through tertiary prevention strategies. Sexual assault programs handle crisis calls from victims and survivors; shelters provide temporary housing for women and children seeking refuge from abuse. The criminal justice system reacts to violent incidents with sanctions for perpetrators. Similarly, health and mental health care professionals treat the presenting problem (suturing lacerations, setting broken bones, and prescribing antidepressants) usually without exploring the underlying problem. In one study of 476 consecutive women seen by a family practice clinic in the Midwest, 394 (82.7 percent) agreed to be surveyed. Of these patients, 22.7 percent had been physically assaulted by their partners within the last year, and 38.8 percent of them endured lifetime physical abuse. However, only six women said they had ever been asked about the occurrence of domestic violence by their physician.[9]

If violence against women is to be stopped, screening and intervention in the health care setting must be supplemented with broad-based public education efforts that inform and address deep-seated attitudes and give people tools for action in the communities in which they live. Despite some gains, far too many Americans continue to hold attitudes that can be construed as excusing the sexual abuser or batterer for his behavior or blaming victims for precipitating the violence. These attitudes contribute to pervasive social norms that tolerate and permit abuse.

Recent public health initiatives to reduce AIDS, smoking, and drunk driving have yielded promising results and significant lessons that can be used to help end violence against women. A campaign sponsored by The Advertising Council encouraged people to speak to their doctors about colon cancer. Widespread response showed that public

health communication of this kind can be an effective tool for addressing topics people feel uncomfortable discussing (as many people do with sexual assault and domestic violence). Not only did The Advertising Council successfully increase awareness of the problem of colon cancer in just 6 months of advertising, it also increased the number of people discussing the issue with their physicians.

Clinical Response: Improving the Standard of Care

Virtually every clinical health and mental health care provider treats victims of sexual assault and domestic violence, although most are unaware that their patients have formerly or recently been abused. Historically, health care providers have viewed violence against women as a social/legal issue or even as a private family problem, outside their purview and inappropriate to address in a clinical setting. Only recently has the situation begun to change. At the clinical care level, health and mental health care institutions and systems are encouraged to implement changes designed to create comprehensive standards of care for victims of violence against women. The standards should include

- Access to health and mental health care. Basic, quality, affordable services should be available to all women regardless of age, geographic or language barriers, sexual orientation, or ability to pay.
- Routine screening by trained health care providers. All adult and teenage women should be screened routinely for intimate partner violence following a screening protocol that ensures patient privacy, safety, and confidentiality. Resources must be invested to develop and test sexual assault screening instruments and to train providers across all health specialties on the use of these tools and appropriate referrals. Screening for violence based on observed injuries alone does not account for the toll of psychological abuse or unseen injuries and eliminates many opportunities for early intervention and prevention. By asking simple and direct questions regarding abuse and sexual assault, trained health care providers engage in vital prevention and early intervention by sending a message to women that violence against them is a health issue, that they are not alone, and that health care providers know and care about sexual assault and domestic violence.
- Documenting violence against women. Acute incidents of sexual assault and domestic violence should be documented accurately, nonjudgmentally, and in detail in the medical record. Documentation of sexual and domestic violence improves both continuity and quality of care by allowing the provider to understand the impact of violence on current and future health problems or injuries. Proper documentation also facilitates reimbursement and referral to additional services, but confidentiality must be maintained throughout the process. Detailed documentation in the medical record also serves as compelling evidence when a victim seeks legal recourse. On a system level, a large number of documented abuse and sexual assault incidents justifies the allocation of additional dedicated services for victims in the medical and mental health care setting. However, more study is needed to determine the best approach to documenting an adult patient's history of child sexual abuse and adult nonacute sexual assault, given how prejudicial such information can be if used improperly.
- Intervention/referral. Once abuse is identified and documented, an appropriate response should ensue. This response may vary depending on the internal and community-based resources of the health care facility and the desires of each survivor. Multidisciplinary protocols that incorporate the roles and responsibilities of all staff who interact with victims of violence against women can ensure that victims receive the support and services they need. Although some health care facilities have in-house advocates to provide victims with resources and support, such as safety assessment and planning or counseling, others might need to partner with local sexual assault and

domestic violence victim advocates and refer appropriately. Regardless of the setting, whether urban or remote rural environments, health care providers must develop culturally competent, creative, and effective strategies to assist victims. Development of a coordinated and collaborative system of referral, followup care, and onsite services is critical in improving the safety, recovery process, and health status of victims.

Clinical interventions should be tailored to respond to the range of racial, ethnic, and socioeconomic characteristics of patients, as well as address the particular needs of women with disabilities and women of all ages and sexual orientation. Literacy levels should also be considered when developing screening questions and patient information.

Integrating Response in All Levels of the Health Care System

The clear lesson of the past two decades of efforts to improve health care's response to violence against women is that the system must be engaged at every level to ensure that meaningful public health efforts and effective sustainable clinical interventions occur. Early efforts focused on creating protocols to guide the care of victims of domestic violence. Although the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that individual health care settings develop written protocols on identifying and responding to sexual assault and domestic violence, protocols unaccompanied by other strategies did not improve screening and intervention. Efforts shifted to supplementing protocols with training for individual providers on the dynamics of and responses to sexual assault and dating and domestic violence. Training, along with increasingly strengthened JCAHO requirements, successfully raised individual provider awareness of and sensitivity to the issue. Single providers, however, have often lacked the organizational support necessary to continue to respond to victims.

Those striving to improve the health care system's response to domestic violence began by training multidisciplinary teams consisting of nurses, physicians, advocates, social workers, and administrators. By organizing and training a range of stakeholders in an institution, awareness and response was more widespread, consistent, and longlasting. These teams met with more success in screening and assisting victims through their policy change efforts, creating a multidisciplinary response, and instituting new clinical tools, but the demands of the increasingly complicated health care system, as well as staff turnover, still make routine screening and response difficult.

To address the particular needs of sexual assault victims who sought medical assistance soon after an assault, a multidisciplinary response was developed, coordinating crisis intervention services and professional forensic evidence collection when the victim wanted to report the assault to law enforcement. For these victims, a new area of medical specialization has evolved, the sexual assault examiner (SAE), also known as SANE (sexual assault nurse examiner) or SAFE (sexual assault forensic examiner). SAEs are trained medical professionals who have advanced education and clinical preparation in the forensic examination of sexual assault victims and who partner with local victim advocates to provide support during the forensic exam and coordinate followup services. When a victim wants to report an assault to law enforcement, existing relationships between the SAE, victim advocate, and police department facilitate a victim-centered response. Some communities have established sexual assault response teams to coordinate these efforts.

Protocols and individual and team training are all crucial, but they must be joined by broader reforms of institutions and policies that affect health care delivery and inform public health strategies.

Addressing Health Care Policy Issues

Confidentiality of health records. An essential corollary to documentation of abuse in medical records is the confidentiality of these medical records. Women who have been sexually assaulted, abused, or stalked share with many other health care consumers concerns about inappropriate access to and use of medical record information by insurance companies, employers, and law enforcement agencies. In addition, victims of domestic violence have the added concern of potential perpetrator access. Few laws exist to prevent spousal access to medical records.

Removing barriers to forensic sexual assault exams and related treatment. One problem is the practice of conditioning medical or forensic services to requirements that the victim report to law enforcement agencies or participate in court proceedings. Such practices compromise sexual assault survivors' access to the emergency health care services they may need and may place them at further risk.

Mandatory reporting to law enforcement by health care providers. With increased recognition that violence against women is a public health issue, some jurisdictions have instituted policies that require a health care provider to report domestic violence, and sometimes sexual assault, to law enforcement authorities. Growing evidence suggests that mandatory reporting may not improve a patient's health and safety and may discourage some victims from seeking medical care. More research is needed on the unintended consequences of these policies and how they affect victims' safety and health before they are established in any more institutions.

Creating reimbursement mechanisms, coding, and other incentives to provide care for victims of violence against women. Currently, no specific Current Procedural Terminology (CPT) codes for domestic violence screening or intervention exist. However, diagnostic codes (995.80–995.85) and e-codes capture additional information such as the nature of the abuse and perpetrators. Although clinicians can use the general preventive medicine codes to bill for domestic violence screening performed in the context of a comprehensive preventive medicine assessment and preventive medicine counseling codes for domestic violence safety assessment and referral processes, there are many compelling reasons to develop procedural codes specific to domestic violence screening and intervention.

First, a specific billing code would provide a direct financial incentive to reward clinicians for the time spent screening and intervening in cases of domestic violence. Second, specific codes would facilitate the process of evaluating how frequently screening is being performed. Third, specific codes for screening and intervention would make it easier for population-based delivery systems to provide feedback to medical groups and individual clinicians on how well they are performing compared with national standards and/or peers. For example, a review of specific coding might reveal how many women per 1,000 were screened in cases of domestic violence or what percentage of screened women received an intervention. Measured performance can be tied to both financial and nonfinancial incentives to drive more rapid improvement. Finally, specific codes for domestic violence screening and intervention would indicate to the health care community that these services are as valuable as other services for which specific codes already exist.

Appropriate use of existing diagnostic codes can be an important source of data about domestic violence and can be used by health plans and other population-based delivery systems to track incidence, associated costs, utilization patterns, and effectiveness of interventions. This type of administrative data can also be used by researchers to answer many important questions about how to design programs that will improve the health care system's response to victims of domestic violence. As documentation and coding for domestic abuse and dating violence is improved, issues concerning confidentiality of the information must be rigorously addressed.

Financial and nonfinancial incentives that promote evaluation and intervention services for victims of domestic violence at all levels of the health care system must be developed and implemented. Purchasers, health plans, and other insurers may be motivated to "buy" or implement comprehensive domestic violence programs if they are presented with the business case for such programs.

In addition to being paid for delivering domestic violence services, clinicians should be encouraged to improve performance. Institutions must prioritize the creation of comprehensive packaged services for victims of dating and domestic violence. Models that require multifaceted responses including medical care, counseling, assessment, case management, and mental health counseling and referrals should be used to create systems that encourage response to dating and domestic violence.

Creating appropriate measures of health outcomes. Much of the contemporary health care delivery is shaped by health outcome measures. Many health issues have obvious means to measure successful treatment or intervention. For example, the treatment of high blood pressure can use simple outcome measures of established ranges of healthy blood pressure to assess the course of treatment and its success. Effective outcome measures must be established to guide care delivery to victims of violence against women.

Outlined below are specific actions that health care professionals; mental health professionals; victim service providers; advocacy groups; public and private health care funders; federal, state, and local government researchers; and others can take to help end violence against women.

Increase Understanding of Violence Against Women as a Critical Public Health Problem

1. Conduct public health campaigns about violence against women at the same level as other large-scale public education campaigns.

- Communicate the serious consequences that violence against women has on all aspects of health and mental health so that the public no longer minimizes the problems or views them as solely private or criminal justice issues.
- Encourage public health leaders, including the Secretary of Health and Human Services, the Surgeon General, and state and local public health figures, to continue to identify sexual assault, dating and domestic violence, and stalking as serious public health issues and call for comprehensive responses.
- Emulate campaign strategies that addressed other health issues that were considered largely private or social in nature. Consider those that resulted in greater willingness of individual providers to screen and intervene and in patient willingness to turn to health care providers for assistance. Campaigns to discourage smoking or to promote safe sex are good examples.
- Integrate messages about violence against women into other health education campaigns. Look for opportunities to include information about sexual assault, dating and domestic violence, and stalking into education that targets behavior often associated with the aftereffects of sexual assault, including but not limited to teen pregnancy, unsafe sex, sexually transmitted diseases, and alcohol and other drug use.
- Target funds to develop campaigns that respond to a wide range of factors, such as race, ethnicity, socioeconomic level, age, disability, and literacy level. Research shows that linguistically and culturally appropriate campaigns are significantly more effective.

Improve the Standard of Clinical Care

2. Educate all health care providers and public health professionals on violence against women.

- Because violence affects so many aspects of physical and mental health and women enter the health care system through various types of providers, institutions, government health programs, and managed care systems, engage

every type of provider, institution, and system in education efforts.

3. Develop professional school curriculums that address violence against women.

- Fully integrate information on violence against women into standard curriculums at all health care and public health professional schools.
- Include information on the dynamics, epidemiology, and direct and indirect effects of sexual assault, dating and domestic violence, and stalking, as well as clinical skills such as screening, documentation, and response.
- Although specialized sections on specific issues are necessary, integrate information about violence against women throughout course work whenever appropriate.
- Offer specific modules on improving the cultural and linguistic competence of practices for all levels of providers. Integrate examples of culturally and linguistically competent practices and cases that deal with various patient populations in training that addresses violence against women.

4. As part of continuing education for providers, offer specific modules on violence against women, and recognize achievements in the field.

- Ensure that training related to violence against women is a component providers receive to become or remain licensed to practice.
- Involve sexual assault and domestic violence advocates and survivors in the development and implementation of continuing education on violence against women.
- Include questions related to both the dynamics and effects of violence against women and appropriate clinical responses on licensure and certification examinations.
- Provide training and promote effective clinical guidelines and standards of care that reflect routine screening, documentation, appropriate assessment, intervention, and referral.
- Create associationwide member awareness campaigns around sexual assault, dating and domestic violence, and stalking.
- Target primary care, reproductive health, emergency, mental health, pediatric, and other specialty organizations that see women regularly.
- Integrate violence against women into association member recognition and honors.
- Increase the availability of technical assistance and training for health care providers who want to become SAEs and professionals who want to improve multidisciplinary responses to sexual assault.
- Follow recommendations of the International Association of Forensic Nurses, which requires the completion of 40 contact hours approved through a recognized continuing education body or offered through a college or university.
- Participate in continuing education and ongoing training to maintain proficiency with new technologies and research findings.

5. Engage all types of providers and institutions.

- Primary care settings offer opportunities for early intervention, and even primary prevention, by identifying sexual or domestic abuse as a health issue in its early stages or before it begins.
- Mental health professionals are key points of contact who see victims for problems of anxiety, depression, posttraumatic stress disorder, suicide attempts, and other psychological problems highly associated with violence against women.
- Obstetricians, gynecologists, women's health nurse practitioners, and nurse midwives are important players because sexual assault survivors often experience anxiety about pelvic examinations and because data suggest that the onset of abuse is often associated with pregnancy.
- Pediatricians and pediatric nurse practitioners can identify victims of domestic violence and offer the resources and support necessary to stop the abuse before it takes its toll on the mothers and children they are treating.[10]
- SAEs see victims of sexual assault as well as victims of domestic violence.
- Dentists and oral surgeons may see women for treatment of oral injuries, such as fractured

jaws, and for regular checkups, during which abuse can be identified by routine screening even in the absence of acute injuries. They may also have patients who have specific fears or reactions concerning their dental care because of a history of sexual assault.

- Substance abuse counselors see many women who are victims of sexual assault and domestic violence and who use alcohol or other drugs as a way of coping with the trauma. Research has shown victimization to be a risk factor for substance abuse.
- Specialists such as orthopedic and plastic surgeons, radiologists, and home health care nurses and attendants each have an important stake in identifying and responding to abuse among their patients. Pain management centers may see many women who suffer from chronic pain due to abuse.
- Inpatient health care settings, such as psychiatric facilities and nursing homes, are urged to work with community sexual assault and domestic violence programs to provide training and develop policies and services that respond to the needs of patients who enter with a history of assault or who are assaulted while in the institution.
- All types of health care organizations must be engaged, including community health centers; home health and visiting nurses agencies; managed care organizations; private hospitals and practices; alternative healing centers; Indian Health Services; military health entities; Women, Infants, and Children and Medicaid programs; and state and federal public health departments and agencies.
- Businesses and other health care purchasers can create the institutional support and incentives that promote training and an improved response by their providers and insurers.

6. Expand SAE programs to all communities throughout the country.

- Increase the capacity of existing SAEs to address the complex health and forensic needs of victims, including the domestic violence victims experiencing forced sex by their partners.
- Provide increased funding and technical assistance to support program development in underserved areas, in collaboration with local and state sexual assault programs and coalitions.

7. Design mental health services to respond to the needs of victims and survivors of sexual assault, dating and domestic violence, and stalking.

- Designate funds to provide quality mental health services for treating the traumatic sequelae of abuse for victims of sexual assault, dating and domestic violence, and stalking, including adult survivors of child sexual abuse living in rural areas.
- Develop collaborative models for addressing the social and advocacy needs and the psychological needs of survivors of sexual assault, dating and domestic violence, and stalking.
- Designate program and training resources to improve quality of care in public mental health systems to address trauma and its sequelae across the lifespan.
- Provide training for community mental health centers to address sexual assault and domestic violence for women diagnosed with serious mental illness and for women who are experiencing other mental health sequelae of sexual assault, dating and domestic violence, and stalking.
- Provide resources for sexual assault and domestic violence victim advocacy programs to provide onsite services and develop contractual arrangements with mental health providers and agencies to address the mental health sequelae of violence against women. Foster greater collaboration between mental health professionals, sexual assault victim advocates, alcohol and other drug abuse treatment providers, and criminal justice personnel.
- Develop curriculums and training materials for mental health providers (e.g., psychiatrists, psychologists, social workers, and marital and family therapists) to address issues faced by women who are being or have been sexually, emotionally, or physically abused.

8. Develop and support the widespread use of provider and institution clinical tools that respond to sexual assault and domestic violence.

- Develop patient charts, new-patient intake forms, and other clinical tools that support appropriate screening, documentation, and response to victims of sexual assault, dating and domestic violence, and stalking.
- Include prompts for providing sexual assault victims with information on available forensic medical examinations in sexual assault protocols, and ensure access to appropriate equipment and staff training on its proper use.
- Post local, state, and national hotline telephone numbers for victims of sexual assault and domestic violence in all examination rooms and patient bathrooms.
- Develop practitioner reference cards that address sexual assault, dating and domestic violence, and stalking. Include sexual assault and domestic violence information on Web sites designed for health care provider and patient reference.
- Equip examination rooms with body maps available for documenting injuries. Equip emergency departments, acute care centers, and other sites that see injuries caused by domestic violence with instant cameras.
- Scrutinize all standard tools to ensure they include information about violence against women.

9. Use funding, licensing, and credentialing mechanisms to ensure that health care institutions have relevant response protocols for violence against women.

- Require grantees to have policies, protocols, training requirements, incentives, and other relevant responses to violence against women.
- Create and strengthen guidelines regarding sexual assault, dating and domestic violence, and stalking, including guidelines for screening.

Address Health Care Policy Issues

10. Fully protect the confidentiality of victims' health records.

- Implement safeguards, under federal, tribal, and state laws, to ensure that health records of victims of sexual assault, dating and domestic violence, and stalking are not accessed inappropriately by insurance companies, employers, or spouses/partners. Protect privileged medical and mental health information from discovery and other legal actions during the course of a criminal proceeding.
- Build into current policy necessary protections for patients who may be endangered under routine directory information, next of kin, and other practices in health care institutions. Allow victims to restrict access to their patient information.
- Allow victims to request that bills and explanations of benefits be sent to alternate addresses.
- Remove information regarding abuse from the records of victims and their children before releasing them to spouses or partners. Notify victims before any required release of abuse-related information to facilitate their safety planning.
- Allow minors who lawfully receive care on their own to restrict access to records regarding abuse.

11. Reduce or eliminate cost and reporting requirements for victims needing forensic medical exams or related treatment after a sexual assault.

- Earmark state funds to cover costs of forensic medical exams for victims of sexual assault without seeking reimbursement from the victim or from any public or private health insurance under which the victim might otherwise be covered.
- Adopt current federal guidelines governing victim compensation agencies, which permit reimbursement of examination costs to hospitals and other medical facilities regardless of whether the assault is reported to law enforcement authorities.
- Include care for acute symptoms and prophylaxis for pregnancy, sexually transmitted disease transmission, and treatment for the hepatitis B virus when appropriate as part of emergency medical care associated with an assault.

12. Amend mandatory reporting laws regarding adult victims of violence to ensure that the laws increase victim safety and health status and do not deter women from seeking care.

- Require patient consent—except in cases of gunshot wounds or life-threatening injuries—before health care providers report violent incidents to law enforcement agencies.
- Increase awareness of the problems that arise from mandatory reporting for women who are undocumented and the subsequent immigration problems.

13. Create reimbursement mechanisms, coding, and other incentives to provide quality care to victims of violence against women.

- Educate clinicians and medical coders on the importance of including the existing International Classification of Diseases, Ninth Revision (ICD–9) codes for adult abuse and e-codes, particularly those that describe the relationship of the perpetrator to the patient, either as primary or secondary diagnostic codes. Failure to add an adult abuse code to the medical record means that information about the root cause of an injury or illness is not captured and therefore may not be appropriately addressed in followup encounters.
- Promote the use of existing ICD–9 codes, including the use of e-codes to define the relationship of the perpetrator to the patient, through medical coder professional organizations, national health care provider organizations, state medical boards, and the use of federal and state government advisories.
- Develop and implement at least two Current Procedural Terminology codes specific to domestic violence screening and intervention.
- Develop the business case for domestic violence services in the health care setting.
- Develop model incentive programs that reward purchasers, plans, other insurers, and clinicians for domestic violence screening and intervention.

14. Provide incentives for individual health care providers to address the violence against women issues of their patients.

- Provide feedback on performance compared to peers and national standards.
- Tie monetary rewards to attaining defined performance goals with respect to screening and intervention.
- Provide public recognition for high performers (e.g., newspaper articles, plaques presented at medical society meetings).
- Design and implement formal mechanisms to give providers feedback from patients who value these services.
- Support the clinician's role in responding to sexual assault and domestic violence by developing in-house services for victims of sexual assault and domestic violence or by contracting with community organizations to provide onsite or on-call access to their specialized services.

15. Prioritize the creation of comprehensive packaged services for victims of sexual assault, dating and domestic violence, and stalking.

- Develop models for delivering multifaceted responses, including medical care, counseling, assessment, case management, and mental health counseling and referrals.
- Examine Medicaid program models, similar to the State Medicaid Perinatal programs that could reimburse health plans for the provision of patient education and case management, safety assessment, and referrals in violence against women cases in low-income communities.

16. Establish appropriate health outcome measures related to improved health care response to violence against women.

- Convene a task force of leading advocates, survivors, health care providers, researchers, and federal representatives to create Health Plan Employer Data and Information Set measures for sexual assault and domestic violence.
- Explore the full range of possible outcome measures, including decreased health care use, fewer secondary health effects related to violence, and victim perception of improved physical and mental health status and safety.

- Develop and provide funds to implement a research agenda that establishes the medical evidence for effective intervention and improved health outcomes and increased safety.

17. Increase funding to improve the health and mental health care systems' response to violence against women.

- Explore the creation of new funding streams that can be dedicated to improving the health and mental health care systems' responses to violence against women.
- Earmark specific funding within state and local health department budgets for improving health care response to sexual assault and domestic violence.
- Provide funds for health care provider training, institutional reform, patient education, and public health campaigns to reflect the prevalence of violence and its impact on health costs.

Emerging Issues

Perpetrators of Violent Crimes Against Women

The health and mental health care systems' responses to perpetrators of sexual assault, dating and domestic violence, and stalking must be assessed. Outside of batterer and sex offender treatment groups, often mandated by courts, virtually no programs exist that respond to perpetrators. State and local agencies, leaders in the sexual assault and domestic violence movement, providers, and perpetrator experts must answer fundamental questions about the health and mental health care systems' responsibility to intervene with perpetrators. Key questions include

- Should patients be routinely screened for perpetration?
- What are the ethical, legal, and safety issues for providers who respond to perpetrators, and what are the safety issues for victims?
- What are effective responses to perpetrators who are not mandated to join batterer or sex offender treatment programs?
- How can more culturally competent batterer and sex offender treatment programs be developed?

Pediatric Responses to Violence Against Women

Although pediatricians clearly must respond to domestic violence because of the documented effects of witnessing violence and the overlap of child abuse and neglect, many questions remain unanswered. State and local agencies and health care institutions should support pilot programs that seek answers to these questions.[11]

- How do providers navigate the complicated ethical, legal, and reporting issues surrounding child abuse and witnessing violence?
- How and when should screening of mothers occur?
- How do child protective services and domestic violence advocates work together in health care settings to ensure the best care and health status for children and their mothers?
- What role can a pediatrician take in responding to abused women?

Another area for ongoing analysis and discussion is pediatric response to a mother, herself a survivor of child sexual abuse, being retraumatized by discovery that her child is being sexually abused. What training, screening, and response protocols are necessary?

Resources

The following list reflects existing national resources. Many state and local sexual assault and domestic violence coalitions, public health departments, professional associations, and health care organizations and institutions have begun to develop programs or policies on sexual assault and domestic violence. Information on local resources can be obtained through state domestic violence

and sexual assault coalitions and national organizations or by contacting local organizations directly.

National Health Resource Center on Domestic Violence
The Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103–5133
Phone: 415–252–8900 or 1–888–RX–ABUSE
Fax: 415–252–8991
Web site: www.fvpf.org/health

The Family Violence Prevention Fund works to end domestic violence and provide women who have been victims of abuse with the care they need to get well and stay safe. The National Health Resource Center on Domestic Violence provides assistance to health care professionals, policymakers, and domestic violence advocates through training tools and manuals, technical assistance, and examination of public policy on local and national levels.

National Sexual Violence Resource Center
123 North Enola Drive
Enola, PA 17025–2521
Phone: 1–877–739–3895
TTY: 717–909–0715
Fax: 717–909–0714
Web site: www.nsvrc.org

The National Sexual Violence Resource Center (NSVRC) is a clearinghouse for resources and research about all forms of sexual violence and assault. NSVRC works with its partner agency, the University of Pennsylvania, to provide new policies for establishing sexual violence intervention and prevention programs.

National Health and Medical Associations

Organizations with substantial resources dedicated to sexual assault and/or domestic violence include the following:

American Academy of Pediatrics
141 NW. Point Boulevard
Elk Grove Village, IL 60007–1098
Phone: 847–434–4000
Fax: 847–434–8000
Web site: www.aap.org

The American Academy of Pediatrics (AAP) advocates to improve the health, safety, and well-being of all children. AAP efforts provide resources and assistance to families, pediatricians, lawmakers, and the community.

American College of Emergency Physicians
1125 Executive Circle
Irving, TX 75038–2522
Phone: 1–800–798–1822
Web site: www.acep.org

The American College of Emergency Physicians (ACEP) seeks to improve patient care and save lives by properly training emergency physicians and fully staffing emergency departments. ACEP also promotes the field of emergency medicine through public education programs and works with national media to increase awareness of emergency medicine issues.

American College of Nurse-Midwives
818 Connecticut Avenue, Suite 900
Washington, DC 20006
Phone: 202–728–9860
Fax: 202–728–9897
E-mail: info@acnm.org
Web site: www.acnm.org

The American College of Nurse-Midwives (ACNM) administers and promotes continuing education programs, accredits midwifery education programs, establishes clinical practice standards, creates liaisons with government agencies and legislators, and provides resources and public education programs that promote the health and well-being of women and infants within their families and communities. ACNM also publishes a journal and codes of ethics for professionals in the field.

American College of Obstetricians and Gynecologists
409 12th Street SW.
P.O. Box 96920
Washington, DC 20090–6920
Web site: www.acog.org

The American College of Obstetricians and Gynecologists (ACOG) promotes wellness for all mothers and their newborn children. Advocating quality health care for women, ACOG promotes continuing education, high standards for clinical practice, and patient understanding of and involvement in medical care. ACOG offers instructional pamphlets and books on pregnancy and infant care and a physician directory to help people locate a doctor.

American Medical Association
515 North State Street
Chicago, IL 60610
Phone: 312–464–5000
Web site: www.ama-assn.org

The American Medical Association (AMA) is the nation's leader in promoting professionalism in medicine and setting standards for medical education, practice, and ethics. A valuable resource for physicians, health professionals, and patients, AMA is concerned about issues ranging from the AIDS epidemic to Medicare. AMA provides information and recommendations on policy and advocacy, scientific journals, and online physician and hospital locator services.

American Medical Women's Association
801 North Fairfax Street, Suite 400
Alexandria, VA 22314
Phone: 703–838–0500
Fax: 703–549–3864
E-mail: info@amwa-doc.org
Web site: www.amwa-doc.org

The American Medical Women's Association champions women's health issues and the advancement of women in medicine. Its efforts focus on issues including violence against women, smoking prevention and cessation, osteoporosis, heart disease, managed care, gender equity in medical education, breast cancer, and reproductive health.

American Psychological Association
705 First Street NE.
Washington, DC 20002–4242
Phone: 202–336–5500 or 1–800–374–2721
Web site: www.apa.org

The American Psychological Association (APA) offers information, services, and advocacy on a range of issues related to science, public interest, education, and practice—including aging, children and families, disability, race and ethnicity, HIV/AIDS, sexual orientation, and women's issues. APA provides tools, training, and leadership related to research and public policy, continuing education and public outreach, and professional ethics.

Association of Traumatic Stress Specialists
7338 Broad River Road
Irmo, SC 29063
Phone: 803–781–0017
Fax: 803–781–3899
Web site: www.atss-hq.com

The Association of Traumatic Stress Specialists (ATSS) provides technical assistance and training to people involved in crisis intervention; trauma response; and the management, treatment, and healing of people who have experienced traumatic distress. ATSS offers numerous resource guides for school officials and other ATSS professionals helping children who have experienced trauma.

International Association of Forensic Nurses
East Holly Avenue, Box 56
Pitman, NJ 08071–0056
Phone: 856–256–2425
E-mail: iafn@ajj.com
Web site: www.forensicnurse.org

The International Association of Forensic Nurses provides direct services to individual clients; consultation services to nursing, medical, and law-related agencies; and expert court testimony in cases dealing with trauma, questioned death investigative processes, adequacy of service delivery, and specialized diagnoses of specific conditions as related to nursing.

International Society for Traumatic Stress Studies
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: 847–480–9028 Fax: 847–480–9282
E-mail: istss@istss.org
Web site: www.istss.org

The International Society for Traumatic Stress Studies (ISTSS) provides a forum for sharing research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world. ISTSS publishes a quarterly journal and coordinates meetings and conferences across the country.

Massachusetts Medical Society
860 Winter Street
Waltham Woods Corporate Center
Waltham, MA 02451–1411
Phone: 781–893–4610 or 781–893–3800
Web site: www.mms.org

The Massachusetts Medical Society works to advance medical knowledge and develop and maintain the highest professional and ethical standards of medical practice and health care. Its program priorities include patient advocacy, health policy, and a care code of ethics.

Nursing Network on Violence Against Women, International
1801 H Street B5
Modesto, CA 95354–1215
Phone: 1–888–909–9993
Web site: www.nnvawi.org

The Nursing Network on Violence Against Women, International advocates to eliminate violence through advancing nursing education, practice, research, and public policy.

Physicians for a Violence-Free Society
1001 Potrero Avenue
Building 1, Room 300
San Francisco, CA 94110
Phone: 415–821–8209
Fax: 415–282–2563
E-mail: pvs@pvs.org
Web site: www.pvs.org

Physicians for a Violence-Free Society promotes violence prevention by developing leadership and advocacy in the health care community. Public education and outreach efforts include presentations on family violence and battered pregnant teens and documentation of injuries that result from family violence; a bimonthly educational newsletter; and violence prevention efforts that encompass domestic violence, child abuse, youth/school violence, elder abuse, hate crimes, and gun violence.

Society for Academic Emergency Medicine
901 North Washington Avenue
Lansing, MI 48906–5137
Phone: 517–485–5484
Fax: 517–485–0801
E-mail: saem@saem.org
Web site: www.saem.org
The Society for Academic Emergency Medicine educates teachers, researchers, and students through forums, publications, collaboration with other agencies, policy development, and consultation services.

Endnotes

1. Coker, A., Smith, P., Bethea, L., King, M., and McKeown, R., (1997). "Physical Health Consequences of Physical and Psychological Intimate Partner Violence." *Archives of Family Medicine* 9(5): pp. 451–457.

Campbell, J., and Lewandowski, L. (1997). "Mental and Physical Health Effects of Intimate Partner Violence on Women and Children." *Psychiatric Clinics of North America* 20(2): pp. 353–374.

Campbell, J. (ed.) (1998). *Empowering Survivors of Abuse: Health Care, Battered Women and Their Children.* Newberry Park, CA: Sage Publications, Inc.

2. Kilpatrick, D., Edmunds, C., and Seymour, A. (1992). *Rape in America: A Report to the Nation.* Charleston, SC: National Victim Center and the Crime Victims Research and Treatment Center, Medical University of South Carolina.

3. Housekamp, B.M., and Foy, D. (1991). "The Assessment of Posttraumatic Stress Disorder in Battered Women." *Journal of Interpersonal Violence* 6(3): pp. 367–375.

Kilpatrick, D. (1984).

4. Gelles, R.J., and Harrop, J.W. (1989). "Violence, Battering, and Psychological Distress Among Women." *Journal of Interpersonal Violence* 4(1): pp. 400–420.

5. Golding, J. (1999). "Sexual-Assault History and Long-Term Physical Health Problems: Evidence From Clinical and Population Epidemiology." *Current Directions in Psychological Science* 8: pp. 191–194.

Houskamp, B., and Foy, D. (1991). "The Assessment of Posttraumatic Stress Disorder in Battered Women." *Journal of Interpersonal Violence* 6(3): pp. 367–375.

Kilpatrick, D., et al. (1985). "Mental Health Correlates of Criminal Victimization: A Random Community Survey." *Journal of Consulting and Clinical Psychology* 53(6): pp. 866–873.

6. Nibert, D., Cooper, S., and Crossmaker, M. (1989). "Assaults Against Residents of a Psychiatric Institution: Residents' History of Abuse." *Journal of Interpersonal Violence* (September) 4(3): pp. 342–349.

Craine, L., Henson, C., Colliver, J., and MacLean, D. (1988). "Prevalence of a History of Sexual Abuse Among Female Psychiatric Patients in a State Hospital System." *Hospital and Community Psychiatry* 39(3): pp. 300–304.

Briere, J., Woo, R., McRae, B., Foltz, J., and Sitzman, R. (1997). "Lifetime Victimization History, Demographics, and Clinical Status in Female Psychiatric Emergency Room Patients." *Journal of Nervous and Mental Disease* 185: pp. 95–101.

7. Rodriguez, M., Bauer, H., McLoughlin, E., and Grumbach, K. (1999). "Screening and Intervention for Intimate Partner Abuse." *Journal of the American Medical Association: Practices and Attitudes of Primary Care Physicians* 282(5): pp. 468–474.

8. Freidman, L.S., Samet, J.H., Roberts, M.S., Hudlin, M., and Hans, P. (1992). "Inquiry About Victimization Experiences: A Survey of Patient Preferences and Physician Practices." *Archives of Internal Medicine* 152(6): pp. 1186–1190.

9. Hamberger, L.K., Saunders, D.G., and Hovey, M. (1992). "Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry." *Family Medicine* 24(4): pp. 283–287.

10. American Academy of Pediatrics Task Force on Adolescent Assault Victim Needs. (1996). "Adolescent Assault Victim Needs: A Review of Issues and Model Protocol." *Pediatrics* 98(5): pp. 991–1001.

11. Spivak, H. (1999). "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level." *Pediatrics* 103(5, part 1): pp. 1080–1081.